97TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT 97–
1st Session } { 119, Part 1

MEDICARE AND MEDICAID HMO AMENDMENTS OF 1981

MAY 21, 1981.—Ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

[To accompany H.R. 3399 which on May 1, 1981, was referred jointly to the Committee on Energy and Commerce and the Committee on Ways and Means]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce to whom was referred the bill (H.R. 3399) to amend titles XVIII and XIX of the Social Security Act with respect to payments to health maintenance organizations, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 3, line 6, strike out "sex,".

Page 3, line 7, insert "and such other factors as the Secretary determines to be appropriate" before the period.

Page 17, line 2, strike out "each individual" and insert in lieu thereof "individuals".

Page 17, line 3, insert "(other than under a contract under subsection (j))" after "section".

Page 23, line 17, insert "the" after "for."

Page 24, strike out line 12 and all that follows through page 25, line 20 and insert in lieu thereof the following:

> (e)(1) Subject to paragraph (2), the amendments made by this section (other than subsections (c) and (d)) shall apply with respect to services furnished on or after the first day of the thirteenth calendar month which begins after the date of enactment of this Act, or earlier with respect to any health maintenance organization if the organization so requests and the Secretary of Health and Human Services agrees, except that such amendments shall not apply—

(A) with respect to services furnished by a health maintenance organization to any individual who is enrolled with that organization under an existing cost contract (as defined in paragraph (3)(A)) and entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act at the time the organization first enters into a new risk contract (as defined in paragraph (3)(D)) unless—

(i) the individual requests at any time that the amendments apply, or

(ii) the Secretary determines at any time that the amendments should apply to all members of the health maintenance organization because of administrative costs or other administrative burdens involved and so informs in advance each affected member of the health maintenance organization;

(B) with respect to services furnished by a health maintenance organization during the five-year period beginning with the date of the enactment of this Act, if—

(i) the organization has an existing risk contract (as defined in paragraph (3)(B)) on the date of the enactment of this Act, or

(ii) on the date of the enactment of this Act the organization was furnishing services pursuant to an existing demonstration project (as defined in paragraph (3)(C)), such demonstration project is concluded before the date such amendments would otherwise apply, and before such date the organization enters into an existing risk contract,

unless the organization requests that the amendments apply earlier; or

(C) with respect to services furnished by a health maintenance organization during the period of an existing demonstration project if, on the date of the enactment of this act, the organization was furnishing services pursuant to the project and if the project concludes after the date such amendments would otherwise apply.

(2)(A) In the case of a health maintenance organization which has in effect an existing cost contract on the date of the enactment of this act, the organization may receive payment under a new risk contract with respect to a current, nonrisk medicare enrollee (as defined in subparagraph (C)) only to the extent that the organization enrolls, for each such enrollee, two new medicare enrollees (as defined in subparagraph (D)).

(B) Subparagraph (A) shall not be construed to prevent a health maintenance organization from providing for enrollment, on a basis described in subsection (c) of section 1876 of the Social Security Act (as amended by this act, other than under a new cost contract), of current, nonrisk medicare enrollees and from providing such enrollees with some or all of the additional benefits described in section 1876

(i)(2) of the Social Security Act (as amended by this act), but (except as provided in subparagraph (A))—

(i) payment to the organization with respect to such enrollees shall only be made in accordance with the terms of a new cost contract, and

(ii) no payment may be made under section 1876 of such act with respect to such enrollees for any such additional benefits.

Individuals enrolled with the organization under this subparagraph shall be considered to be individuals enrolled with the organization for the purpose of meeting the requirement of section 1876(i)(2) of the Social Security Act (as amended by this act).

(C) For purposes of this paragraph, the term "current, nonrisk medicare enrollee" means, with respect to an organization, an individual who on the date of the enactment of this act—

(i) is enrolled with that organization under an existing cost contract, and

(ii) is entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act.

(D) For purposes of this paragraph, the term "new medicare enrollee" means, with respect to an organization, an individual who—

(i) is enrolled with the organization after the date the organization first enters into a new risk contract,

(ii) at the time of such enrollment is entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act, and

(iii) was not enrolled with the organization at the time the individual became entitled to benefits under part A, or enrolled in part B, of such title.

(3) For purposes of this subsection:

(A) The term "existing cost contract" means a contract which is entered into under section 1833(a)(1) of the Social Security Act or under section 1876 of such act, as in effect before the date of the enactment of this act, and which is not an existing risk contract or an existing demonstration project.

(B) The term "existing risk contract" means a contract entered into under section 1876(i)(2)(A) of the Social Security Act, as in effect before the date of the enactment of this act.

(C) The term "existing demonstration project" means a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, relating to the provision of services for which payment may be made under title XVIII of the Social Security Act.

(D) The term "new risk contract" means a contract (other than a new cost contract) entered into under section 1876 of the Social Security Act, as amended by this act.

(E) The term "new cost contract" means a contract entered into under section 1833(a)(1) of the Social Security Act or under section 1876(j) of the Social Security Act, as amended by this act.

Page 30, line 7, insert "not" after "are".

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I. Legislative Background

Legislation to amend Titles 18 and 19 of the Social Security Act to revise the manner in which health maintenance organizations are reimbursed under Medicare and Medicaid, H.R. 2508, was introduced on March 12, 1981 by Mr. Waxman, Mr. Gramm, and Mr. Pepper. Hearings were conducted on H.R. 2508 and all similar or identical bills on March 18, 1981. The bill as considered in open executive session by the Subcommittee on Health and the Environment on April 29, 1981, amended, reported, and reintroduced as a clean bill, H.R. 3399 on May 1, 1981 by Mr. Waxman, Mr. Scheuer, Mr. Walgren, Mr. Wyden, Mr. Shelby, Mr. Gramm, Mr. Leland, Mr. Broyhill, Mr. Madigan, Mr. Brown of Ohio, and Mr. Ritter.

H.R. 3399 was considered by the Energy and Commerce Committee on May 12, 1981, amended and ordered reported by a unanimous voice vote.

II. Summary of Legislation

The purpose of this legislation is to amend Titles 18 and 19 of the Social Security Act to revise the manner in which Health Maintenance Organizations (HMO's) are reimbursed under Medicare and Medicaid; and to amend section 1122 of the Social Security Act to revise the scope of review of capital expenditures under that section.

As approved by the Committee, H.R. 3399 would amend existing law in the manner described below.

Reimbursement of HMO's by Medicare

The bill would revise a medicare reimbursement option currently available to health maintenance organizations (HMOs) in order to make the option more attractive to them. Under present law HMOs may choose to be paid on the basis of either incurred costs or a risk reimbursement formula. Almost all HMOs have chosen the former option because the current risk formula involves a number of retro-

spective adjustments that HMOs find undesirable. The current formula would be replaced by a prospective formula that would reimburse an HMO at 95 percent of the average medicare cost per capita for medicare beneficiaries in the HMO's geographic area. If the actual amount of reimbursement exceeds what the HMO would have been reimbursed under its usual rating system, the HMO would be required to provide its medicare enrollees additional benefits that are actuarially equal to the excess. Medicare beneficiaries enrolled in HMOs choosing the new risk formula could decide whether or not they wanted their benefits to be financed on this basis.

REIMBURSEMENT OF HMOS BY MEDICAID

As approved by the Committee, the bill would amend the current medicaid statute by (1) authorizing States to enter into risk-based payment arrangements with HMOs that meet medicare standards as well as with HMOs that meet Title XIII (Public Health Service Act) standards; (2) raising the ceiling on the number of medicare and medicaid beneficiaries who may be enrolled in an HMO participating on a risk basis in medicaid from 50 to 75 percent of the HMO's membership; and (3) authorizing States to enter into contracts with HMOs under which Medicaid eligibles would be covered for a minimum period of up to six months from initial enrollment. In addition, the bill clarifies that any prepaid capitation or other risk-based payment arrangements between a State Medicaid Agency and an HMO may be undertaken only pursuant to a contract meeting certain minimum specifications.

CAPITAL EXPENDITURE REVIEW UNDER SECTION 1122

Capital expenditure review under section 1122 would be amended to make it consistent with coverage of capital expenditures under the certificate of need provisions of the Health Planning Act (section 1527 of the Public Health Service Act).

III. Background for Proposal

As used most generally, the term health maintenance organization describes an entity which provides specific health services to its members for a prepaid, fixed payment. In one respect, this arrangement is like a traditional health insurance program in the fee-for-service system. A monthly payment insures some portion of the costs of health services which a subscriber may incur during a period of time.

However, an HMO is different from the fee-for-service system and traditional health insurance programs in at least three respects. First, it is different in its approach to payment to providers of health care services. In an HMO, providers are at risk and are not reinbursed for each of the services they provide, as physicians in the fee-for-service system generally are.

Second, HMOs can be distinguished from a traditional health insurance program in the fee-for-service system by either providing directly or arranging to have provided those services specified in the HMO subscriber contract. A member of a Blue Cross/Blue Shield

plan or other private health insurance plan in a fee-for-service arrangement does not have services provided by the plan. Rather, the member secures his own services from various providers and the plan then pays.

Finally, while a member of an HMO most often is allowed to choose his own physician within the plan, the member is not allowed, except under extraordinary circumstances of medical emergency, to seek care from physicians or other providers outside the plan.

These aspects of the HMO concept are designed to provide the HMO a capacity and a financial incentive to control the use of health services so as to reduce overall health care costs.

The term health maintenance organization was first advanced in 1970 and includes two basic HMO models: (1) the prepaid group practice model, and (2) the individual practice association or medical care foundation model. In both models, the HMO receives periodic payments of fixed amounts in return for the services it provides to HMO members.

Under the group practice model most medical services are provided by physicians who are members of a group practice. Such physicians may be either employees of the HMH (in which case the HMO is often referred to as a staff model) or members of a separate entity which contracts with the HMO to provide medical services to HMO members. Physicians in these arrangements are paid in a variety of ways—the two most common being by salary, or through arrangement where the group is paid fixed payments per member each month.

Under the individual practice association or IPA model, physicians in a community contract with the HMO to provide medical services out of their private offices, which can be either solo or group practices. Physicians in IPAs are generally paid on a modified fee-for-service basis with retrospective adjustments based on performance by the HMO and the individual physician. In other words, the fewer expenses incurred by the HMO by the end of the year, the higher the income for physicians.

Group practice HMOs either own their own hospitals, such as is the case for most Kaiser Foundation Health Plans, or arrange for hospitalization for members at one or more community hospitals. The latter arrangement is used in most group practice HMOs, and in almost all individual practice association HMOs.

Because providers are at risk and are not reimbursed for each of the services they provide, HMOs alter the usual economic incentives in medical care and give providers a stake in holding down costs. Studies have found that the total cost of medical care (i.e., premium plus out-of-pocket costs) for HMO enrollees is lower than it is for comparable people with conventional insurance coverage. The lower costs are clearest for enrollees in HMO group practices, where total costs are from 10 to 40 percent below the costs of conventional insurance enrollees.

Most of these cost differences have been found to be the result of hospitalization rates lower than those of conventionally insured populations. These lower hospitalization rates are due almost entirely to lower admission rates; the average length of stay of a person in a hospital shows little difference in the HMO as opposed to the conventional arrangement.

For example, the last National HMO Census of Prepaid Health Plans indicated, for 1979, the inpatient hospital utilization rate for all HMO plans was 412 days per 1,000 members per year. This compares to an average of about 730 days per 1,000 Blue Cross enrollees nationally in 1978.

In addition, physician visits per member per year for all HMO plans averaged 3.4, and total health plan encounters, including those with the HMOs' nurse practitioners or physicians assistants, per member per year for all plans averaged 4.5 in 1979. The national average was about 5 physician visits per person per year.

The cost-savings potential of HMOs has important implications for public programs. One study of Medicaid eligibles enrolled in a Washington, D.C., HMO shows that for the same benefit package, annual per capita costs for 1,000 Medicaid enrollees for 1972, 1973, and 1974 were $282, $232, and $286 respectively compared with Medicaid fee-for-service per capita costs of $373, $435, and $465 over the same period. Significant and consistent decreases in all four categories of utilization—physician encounters, drug prescriptions, hospital admissions, and hospital days—were found for this group. Overall ambulatory physician encounter rates decreased 15 percent; drug utilization was down 18 percent; hospital admissions decreased 30 percent; and hospital days declined 32 percent after enrollment in the HMO.

An analysis of 1977 data collected in California under the Prepaid Health, Research, Evaluation and Demonstration Project (PHRED) indicates that 13 plans with 104,000 enrollees produced a 16.9 percent savings for the State over costs for fee-for-service beneficiaries. The State of Massachusetts reports comparable savings. In 1977 Medicaid enrollees in the Harvard Community Health Plan produced savings for the State of 19.2 percent compared with eligible persons covered on a fee-for-service basis.

Available evidence also suggests savings for Medicare beneficiaries. Data from seven group practice HMO plans compared with control groups in the same geographic areas—and standardized for age and sex differences—show that in five of these plans, the HMOs saved up to 34 percent over the fee-for-service care provided to the control groups.

IV. Committee Proposal Overview

The Committee conducted hearings on and considered this bill and a companion bill, H.R. 3398. The Committee found that existing HMOs, in general, are delivering quality health care, restraining increases in health care costs in their areas, and stimulating the development of additional HMOs and other pre-paid health care plans in their areas. The number of HMOs and their enrollment is growing significantly, due in large part to the efforts of the Federal grant and loan program conducted by the Office of Health Maintenance Organizations; and the amount of private investment and development has increased (see section entitled Background for data).

With regard to Medicare reimbursement of HMOs, the Committee heard convincing testimony that HMOs can provide Medicare benefits for significantly less cost than the fee-for-service sector. Two of the

Committee's witnesses are currently conducting demonstrations, under contract with the Department of Health and Human Services, of the risk based reimbursement scheme provided for in this bill. Medicare beneficiaries enrolled with those two HMOs have all or most of their out-of-pocket expenses for medicare covered services paid for by the HMO out of the savings generated by the HMO; and in addition, Medicare saves 5 percent of what it would have cost for the same beneficiaries in the fee-for-service system.

The Committee believes that this bill overcomes the problems of current law, under which only one HMO has entered into a risk contract. It will encourage HMO participation and enrollment by Medicare beneficiaries and will result in substantial savings to Medicare. Most importantly, it will promote the continued growth of HMOs and increase their ability to compete with the free-for-service system.

The Committee strongly recommends the policy of promoting HMO development. HMOs have tremendous potential for cost containment, while maintaining quality, because they are the *only* health care organizations in the country today which integrate the delivery of health care services with its financing and reimbursement. An HMO contracts with its members to make providers (such as physicians, other health care professionals and hospitals) available to provide services; and it contracts with its providers to provide them. An insurance plan (including Blue Cross and Blue Shield) contracts with its insureds or members to reimburse them or pay their provider for services if the insured or member finds the provider; its relationship with providers is an agreement to make payments for services provided. The relationship between the HMO and its providers enables it, through its organizational structure or through financial incentives or risks, to control utilization (particularly inpatient hospital care) and thus costs. While insurance plans can and have taken many steps to reduce utilization, their "fee-for-service" relationship with providers does not permit them to implement the same kind of utilization controls. The result is that their costs, for the same services, are generally higher.

REIMBURSEMENT OF HMOS BY MEDICARE (SECTION 1)

The Committee's bill would provide reimbursement for health maintenance organizations on the basis of a prospectively determined per capita amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries outside the HMO. Any difference between the HMOs adjusted community rate (adjusted for the higher utilization of the elderly and disabled) and the medicare reimbursement would be returned to medicare beneficiaries in additional benefits.

Under present law, health maintenance organizations may contract for medicare reimbursement on either a cost or risk basis. However, only one HMO has opted to be reimbursed under the existing risk formula. HMOs have generally found the risk reimbursement formula unacceptable because retroactive adjustments are made which take into account the costs actually incurred by the HMO. The new risk formula would provide a prospectively determined per capita payment for each enrollee. The Committee recognizes that HMOs, in the

non-medicare portion of their business, receive a fixed, prospectively determined payment per enrollee which is not related to the amount of care. This payment per enrollee acts as a limit on HMO revenues, creating financial incentives for the organization to control costs and to provide the least expensive service appropriate to the enrollee's needs. These incentives are passed on to the physican by paying him on a salary basis, providing a bonus or profit sharing arrangement when costs are kept low, or providing other meaningful incentives for him to control costs and utilization.

Under the Committee's bill, the rates of medicare payment under the risk contract would be set at 95 percent of the per capita amount that would be paid by medicare for services provided to an enrolled beneficiary (classified by actuarial factors such as age) by other providers in the geographic area of the HMO. For example, the rate of payment for a 65 year old beneficiary would be lower than the rate for an 85 year old beneficiary.

The Committee recognizes that the Secretary needs broad discretion in selecting actuarial factors which are appropriate for this purpose. The Committee, therefore, amended the proposed section 1876(a)(3) by adding the phrase "and such other factors as the Secretary determines to be appropriate". However, the Committee expects that the Secretary will carefully evaluate the validity of every factor he proposes to use. Since the Committee was particularly concerned about the use of "sex" as an actuarial factor, the Committee also deleted the word "sex" from the same proposed section to make clear that the bill does not require using "sex" as an actuarial factor. In any event the use of any actuarial factor pursuant to such proposed section does not and should not affect in any way the benefits or the out-of-pocket expenses (deductibles and co-insurance) of medicare beneficiaries or their opportunity to enroll in an HMO.

The second important feature of the bill's risk reimbursement formula requires the HMO to provide to enrolled medicare beneficiaries increased benefits or reduced cost-sharing, to the extent that the medicare reimbursement exceeds the HMO's adjusted community rate. This appreach would create incentives for medicare beneficiaries to enroll in HMO's and assure that the economies realized through HMO efficiencies, in excess of the HMO's usual profit and other retained funds, accrue to beneficiaries. The HMO would determine that additional benefits, reduced beneficiaries cost sharing or combination of the two are most appropriate for its medicare enrollees. The Secretary would be required to report to the Congress three years after enactment on the type and amount of additional benefits which are being provided. The Committee's bill also requires the Secretary to study and report to the Congress the causes for beneficiary disenrollment from HMO's under medicare contracts, paying particular attention to the utilization and quality of services provided these beneficiaries and their medical condition prior to disenrollment.

If an HMO with an existing cost based reimbursement contract elects to enter into a new risk based contract, the medicare beneficiaries enrolled with the HMO at the time the new contract first applies would have an option. They could continue to receive their medical care either inside or outside the HMO and be reimbursed by medicare in

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the current manner; or they could receive services furnished only by or through the HMO (be "locked-in") and have the HMO receive all payments through the new risk contract. The advantage to them of being locked-in is that they could then receive the additional benefits offered by the HMO when its adjusted community rate is less than its payment from medicare. If the Secretary found there were administrative costs or other administrative burdens involved in allowing the HMO to be reimbursed under both cost and risk contracts, he could require all medicare enrollees to be locked-in.

If the HMO had the cost based reimbursement contract on the date of enactment of this bill, then the HMO would be limited in the number of those medicare beneficiaries who were enrolled at the date of enactment who could be reimbursed under the risk contract. One of those enrollees could be included in the risk contract for each two medicare beneficiaries who enroll after the HMO enters into the risk contract. This limitation on medicare beneficiaries participating in the risk contract would apply only to those beneficiaries who are enrolled with the HMO on the date of enactment of this bill. This conversion formula was included to reduce the increase in outlays to medicare due to the new risk reimbursement.

To mitigate the adverse effect on those Medicare enrollees who wish to participate in the risk contract and receive the additional benefits, but cannot because of the conversion formula, an HMO would be allowed to receive cost based reimbursement for them but share with them the additional benefits accruing to Medicare enrollees under the risk contract. If they elected to receive additional benefits they would be locked in.

There are some medicare beneficiaries currently locked into HMOs. They are enrolled in the one current risk contract or are participating in one of the several demonstrations of risk based systems. To protect them, the Committee's bill would delay the mandatory application of the new risk based contract requirements on those HMOs for five years or until the demonstrations are completed. At that time those HMOs would have to choose between cost based or the new risk based reimbursement. If they selected risk, all Medicare beneficiaries enrolled under the old risk contract or the demonstrations could enroll under the new risk contract and the conversion formula would not apply.

An HMO would be defined as a public or private organization which is organized under the laws of any state. It would include both federally qualified HMOs and other HMOs which are constituted in accordance with requirements spelled out in the bill. The Committee carefully developed these requirements so that HMOs which are not federally qualified would be eligible to participate in this new Medicare reimbursement system.

In some parts of the country HMOs have developed without the advantages of being federally qualified. If they realize their potential for operating in a cost efficient manner, they will exert strong competitive pressure on health insurance plans (and thus fee for service providers) to reduce the cost of health services and expand the services offered in their benefit plans. It is the Committee's view that these HMOs are capable of serving medicare beneficiaries as well as any other health care providers. It would be inappropriate and unnecessary to require these HMOs to become federally qualified in order

to participate in this new medicare reimbursement scheme as long as there are assurances that their medicare and other enrollees are satisfied with the care they receive.

An HMO which is not federally qualified must meet five requirements. First, the organization must provide the following comprehensive range of health care services to enrolled members: physicians services, inpatient hospital services, laboratory, X-ray, emergency and preventive services and out of area coverage. Preventive health services would include services such as voluntary family planning, well child care, periodic health evaluation for adults and pediatric and adult immunizations.

Second, the organization must be compensated (except for deductibles, co-insurance and co-payments) for the provision of health care services to a member by a fixed periodic payment which is unrelated to the frequency, extent, or kind of health care services actually provided to that member.

Third, the organization must provide physician services either (1) directly through physicians who are either employees or partners of the organization, or (2) though contracts with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

One of the most important features which distinguishes an HMO from a health insurance plan is that an HMO contracts with its members to make physicians available to them to provide necessary services while an insurance plan contracts with its insureds to pay for physicians' services if the insured individuals locate the physicians. If the HMO does not have contracts with its physicians it could not assure its members of the availability and accessibility of their physicians.

Fourth, the organization must assume full financial risk on a prospective basis for the provision of its health care services. Exceptions to this requirement are that the organization may (1) obtain insurance or make other arrangements for the cost of providing health care services to any one enrollee in excess of $5000 a year, for the cost of out-of-area medically necessary services, and for up to 90 percent of the amount by which its costs for any fiscal year exceed 115 percent of its income for that year; and (2) share all or part of the risk for the provision of services to members with the physicians, other health care professionals, hospitals, and other institutions which provide those services to members. The assumption of financial risk on a prospective basis is an essential characteristic of an HMO. Because an HMO provides services within a fixed annual budget it constantly seeks to control its costs. It is the Committee's view that an HMO cannot contain its costs if it does not promote efficient utilizaion of services and facilities by its physicians and other health care providers. The Committee intends for HMOs to use mechanisms, such as risk sharing, financial incentives or other incentives, with their physicians to encourage them to monitor utilization, achieve utilization goals and thereby control costs.

And fifth, the organization must make adequate provision against the risk of insolvency. Without this requirement individuals enrolled could be subject to the unexpected bankruptcy of their HMO and subsequent disruption of their health care services.

If an organization meets these five requirements it would be considered a health maintenance organization for purposes of reimbursement under medicare. In order to participate in medicare, however, it must also meet for its medicare beneficiaries certain conditions of participation. (Federally qualified HMOs must also meet these conditions.)

There are eight conditions of participation. First, the HMOs minimum benefit package must include the services to which a medicare beneficiary is entitled. It may include additional health care services at the option of the medicare beneficiary or if the Secretary approves such additional services. The purpose of permitting Secretarial approval of a broader minimum benefit package is to allow an HMO to offer Medicare beneficiaries the same minimum benefit package offered non-Medicare enrollees. (The HMO could add services to those approved by the Secretary only at the election of the Medicare beneficiaries.) If the Secretary determined that including additional services would substantially discourage enrollment by Medicare beneficiaries, then the Secretary would not approve the addition. Under any circumstance the HMO is required to inform medicare beneficiaries of the portion of their premium rate or other charges which are applicable to any additional services.

Second, the HMO must limit the amount of premium or other payments charged to its medicare enrollees for their entitled benefits to the actuarial equivalent of medicare deductibles and coinsurance that would apply to these beneficiaries were they not enrolled in the HMO. Any premium charged and the actuarial value of any deductible, co-insurance or co-payment charged for additional services (described in the preceding paragraph) could not exceed the adjusted community rate for those services.

Third, the HMO must provide services to medicare beneficiaries through institutions, entities and persons meeting the applicable requirements of Sec. 1861 of the Social Security Act.

Fourth, in order to assure that an HMO makes a genuine effort to enroll medicare beneficiaries, the HMO must have an open enrollment period of reasonable duration at least every year during which it accepts medicare beneficiaries up to the limits of its capacity and without restrictions in the order in which they apply for enrollment. This requirement is necessary since most HMOs enroll only groups and medicare beneficiaries, in many instances, would be enrolling as individuals. Without assurance of open enrollment, such medicare beneficiaries would have no access to the HMO. No HMO, however, would have to accept proportionately more medicare enrollees than are represented in the population in the geographic area served by the HMO.

Fifth, the HMO must (1) provide assurances to the Secretary that it will not expel or refuse to re-enroll any medicare individual because of that individual's health status or requirement for health care services, and (2) notify each medicare beneficiary of such fact at the time of the individual's enrollment.

Six, the HMO must make its services available and accessible to medicare beneficiaries within the area served by the HMO promptly and in a manner which assures continuity. When medically necessary, those services must be available and accessible 24 hours a day and seven

days a week. The HMO must also reimburse a medicare beneficiary if he or she paid for medically necessary and immediately required health care services rendered outside the HMO's service area.

Seventh, the HMO must provide meaningful procedures for hearing and resolving grievances between the HMO (including any entity or individual through which it provides its health services) and medicare beneficiaries.

And eighth, the HMO must have arrangements, established in accordance with regulations of the Secretary, for an on-going quality assurance program for health care services it provides to medicare beneficiaries.

Because federally qualified HMOs and other HMOs will participate in this medicare program, the committee intends for the Office of Health Maintenance Organizations in the Department of Health and Human Services to play a major role in determining whether an organization seeking participation under this provision meets the HMO definition and complies with the conditions of participation. Since many of the conditions of participation are similar to requirements for federally qualified HMOs, those conditions should be interpreted consistently with the requirements of Title XIII of the Public Health Service Act.

Federally qualified HMOs must set their premiums under a "community rating system" which is defined in Section 1302(8) of the Public Health Service Act. Because the Committee expands the definition of HMOs to include organizations not federally qualified, the Committee's bill permits an HMO to develop an adjusted community rate for its medicare beneficiaries based upon its weighted aggregate premium for non-medicare beneficiaries. The adjustment of the weighted aggregate premium would be made in a manner similar to the adjustment of the community rate of a federally qualified HMO.

To insure that non-federally qualified HMOs which meet the definition of the Committee's bill disclose their ownership and related information in accordance with section 1124 of the Social Security Act, the Committee's bill modifies the definition of HMOs in Section 1124 so that it includes HMOs as defined in the Committee's bill.

During the Committee's deliberation some concern was expressed that HMOs will unduly benefit from participation in this program. It is the Committee's view that HMOs will benefit because this new system of reimbursement for medicare beneficiaries is consistent with their mode of operation for their other enrollees. An HMO will be paid an amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries in its area, but the HMO will retain only that portion of the amount equal to its adjusted community rate. The difference will be returned to its medicare beneficiaries. An HMO will be required to conduct an open enrollment period during which it must accept medicare beneficiaries in the order in which they apply for enrollment. Because medicare beneficiaries are older they require considerably more health services; so an HMO will be assuming substantial financial risk during this open enrollment period.

Concerns were also expressed to the Committee that because non-federally qualified HMOs will be permitted to participate medicare beneficiaries will be subjected to significant abuses by unregulated

HMOs. The Committee also believes that this concern is unfounded. If a medicare beneficiary believes that he or she has received inadequate services or determines that he or she does not want to continue enrollment for any reason, they may terminate enrollment with one month's notice. In addition, an HMOs medicare and medicaid enrollment cannot exceed 75 percent of its total enrollment. This provision, more than any other, will assure that participating HMOs are stable, well managed community businesses. If they do not satisfy the health care needs of their non-medicare enrollees, so that they disenroll and their number decline below one-quarter of the total enrollment, the HMO cannot continue participating in this medicare program.

The Committee's bill would permit an HMO to select reimbursement on either a risk basis, as established by the bill, or a cost basis as currently provided in section 1876.

CAPITAL EXPENDITURE REVIEW UNDER SECTION 1122

The Committee's bill also amends Section 1122 of the Social Security Act. That section provides for review of capital expenditures made by or on behalf of a health care facility which is reimbursed under the Social Security Act. Under the current provisions of Section 1122, capital expenditures to be made by an HMO for the development of a health care facility would be reviewed. In the Health Planning and Resources Development Amendments of 1979, Public Law 96–79, the Congress determined that certain capital expenditures made by HMOs should not be covered by state certificate of need programs. (These programs are required by Title XV of the Public Health Service Act.) The Committee believes that review under Section 1122 and under Title XV should be consistent. The Committee's amendment would modify Section 1122 to exclude from review a capital expenditure made by or on behalf of a health care facility if the obligation of the expenditure would not be required to be reviewed under Section 1527 of the Public Health Service Act.

This amendment does not impose any new requirement for review under Section 1122. For services which are not required by Title XV to be included in a state certificate of need program, such as home health services, those services would only be reviewed under Section 1122 if the section provided for such review.

REIMBURSEMENT OF HMO'S BY MEDICAID SECTION (2)

The section defines the circumstances under which State Medicaid Agencies may make payments to entities on a prepaid capitation basis (or any other risk basis) on behalf of medicaid eligibles. State would be authorized to make risk-based payments under medicaid to HMOs that met either Public Health Service Act requirements or medicare participation requirements. In addition to meeting one of these qualification standards, an HMO participating in medicaid on a risk basis would have to meet requirements relating to benefits, disenrollment policy, availability of services, grievance procedures, and quality assurance.

The section provides that any risk-based payment arrangement between a State Medicaid Agency and qualified HMO would have to be

undertaken pursuant to a contract meeting certain specified assurances. Further, within three years of entering into such a contract, an HMO would be required to have a membership of which at least 25 percent of the enrollees were not medicare or medicaid beneficiaries; the Secretary would be authorized to waive this requirement for public entities. Finally, the section authorizes States to negotiate enrollment periods of up to 6 months for medicaid eligibles choosing to enroll in HMOs, with the assurance that Federal matching funds will be available regardless of any changes in their eligibility during that period.

Under current medicaid law, States may enter into prepaid capitation or other risk basis payment arrangements only with entities that the Secretary has determined meet the HMO standards under Title XIII of the Public Health Service Act. In addition, within 3 years of entering into a contract with the State, an HMO must have an enrollment composed of no more than one half medicare or medicaid beneficiaries. These requirements do not apply to certain entities identified in regulation as Prepaid Health Plans (PHPs), principally community health centers and rural primary health care entities that were receiving grant funds in fiscal year 1976.

The Committee is concerned that current medicaid law does not provide sufficient encouragement for HMO participation in the medicaid program. As of June, 1980, only 17 State Medicaid Agencies had entered into risk-based payment arrangements with HMOs (or PHPs); these contracts covered some 270,000 medicaid enrollees, or just a little over one percent of all medicaid eligibles. In view of the demonstrated cost-effectiveness of HMOs, the Committee believes that more medicaid eligibles should have the choice of receiving care from a qualified HMO. This will require greater State Agency activity as well as greater interest and initiative on the part of HMOs. However, because current qualification standards have in some cases created unnecessary barriers to HMO participation in medicaid, the Committee has recommended the following changes.

As under current law, a State would be authorized to contract on a risk basis with federally qualified HMOs, that is, entities meeting the requirements of section 1310(d) of the Public Health Service Act. (It should be noted that, in a companion bill, H.R. 3398, the Committee is recommending various changes in these Federal qualification standards). The Committee bill would also authorize States to contract on a risk basis with HMOs that meet the requirements for medicare participation put forth in section 1 of the Committee bill). In addition to meeting either the Federal qualification or medicare participation standards, an HMO would also have to meet requirements relating to benefits, expulsion of members, availability of services, grievance procedures, and quality assurance (to the extent that requirements are not already met through the initial qualification process).

The bill requires that the HMO offer to its medicaid enrollees at least the following mandatory benefits (as provided for under the State Medicaid plan): inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, early and periodic screening, diagnosis, and treatment services for children under 21, family planning services and supplies, and home health services. The

State Agency and the HMO may, of course, contract for provision of additional mandatory or optional services covered under the State plan. The HMO must make these services available and accessible to medicaid enrollees within its service area and must provide for reimbursement for out-of-area services in the event of unforeseen illness, injury, or condition. In addition, the HMO must have arrangements for an ongoing quality assurance program for the services it provides to medicaid eligibles, and must establish meaningful grievance procedures for such enrollees. The HMO would be prohibited from expelling or refusing to reenroll any medicaid eligible due to the individual's health status or requirements for health care services.

An entity that met these requirements would be qualified to enter into a risk-basis payment arrangement with a State Medicaid Agency. The Committee bill clarifies current law to require that any such arrangements be undertaken under contract. The contract must provide that the State or the Secretary has the right to audit and inspect the records pertinent to the HMO's financial solvency, services provided, or payments received under the contract. The contract must also prohibit the HMO from discrimination among medicaid eligibles on the basis of health status or need for health care in its enrollment policies or procedures. The purpose of this prohibition, which is intended to benefit both the State and eligible recipients, is to avoid "skimming" of low-risk medicaid eligibles by contracting HMOs. Finally, the contract must provide that the HMO notify each medicaid eligible, at the time of enrollment, of that individual's right to disenroll, without cause, upon one month notice. This provision is intended to assure that medicaid eligibles have the option to seek care promptly from competing providers should they become dissatisfied with the service or performance of the HMO in which they are enrolled.

The Committee bill alters the current limitation with respect to medicare and medicaid enrollment in HMOs participating in medicaid. With the exception of certain statutorily-identified entities (PHPs), HMOs participating in medicaid currently are prohibited from having an enrollment that consists of half or more medicare or medicaid eligibles. This requirement, which applies 3 years after the HMO first enters into a medicaid contract, was first established in 1976 (Public Law 94–460) in response to Congressional concerns about the adverse quality implications of "poor people's HMOs," especially the tendency to underserve enrollees. These concerns, which derived mainly from the experience under the California Prepaid Health Plan Program in the early 1970's, remain applicable today, notwithstanding improvements in the art of quality assurance in HMOs since then. At the same time, the Committee recognizes that, in some areas, the 50-percent limitation on medicare and medicaid enrollment may be unrealistic, even with a 3 year compliance period. Accordingly, the Committee bill would raise the ceiling on combined medicare and medicaid enrollment to 75 percent. (It should be noted that, under section 1 of this bill, total medicare enrollment in an HMO would be limited to 50 percent.) The requirements in current law that the HMO demonstrate continuous efforts and progress toward compliance with the 75-percent ceiling during each of the 3 years would remain unchanged. This will assure that within 3 years of the initiation of a contract between an

HMO and a State Medicaid Agency, at least one out of every four enrollees will be a private enrollee.

The Committee bill provides the opportunity for a waiver of this new 75 percent limitation on medicare and medicaid enrollees in the case of public entities. The Committee understands that this ceiling may preclude some county and municipal hospitals and health departments from establishing a viable HMO, because the patient mix in their service areas consists largely, if not exclusively, of public program beneficiaries and persons with no other source of payment. Under these circumstances, it may well be unrealistic to expect a public hospital or clinic-based HMO to achieve 25 percent private enrollment within 3 years of entering into a medicaid contract. The Committee bill therefore authorizes the Secretary to modify or waive the limitation for public HMOs, for such period as he or she deems appropriate, if special circumstances (such as the high proportion of medicare and medicaid beneficiaries in the HMO's service area) warrant and if the HMO is making reasonable efforts to enroll nonmedicare or nonmedicaid members. The Committee intends that the Secretary periodically review any such modifications or waivers to assure that the public HMOs are in fact continuing to make reasonable efforts to enroll members of private or public employee groups in their service areas.

The Committee bill authorizes, but does not require States to negotiate an enrollment period of up to 6 months, for medicaid eligibles who elect to enroll in an HMO, with the assurance that Federal matching funds will be available for the HMO coverage for the individul during that period. Under current law, if a medicaid beneficiary enrolls in an HMO in one month and shortly thereafter loses his or her eligibility for benefits due to excess income, the HMO must be denied payment for services provided after the individual becomes ineligible. From the HMO's standpoint, this makes the medicaid market unstable and therefore unattractive. The Committee bill would therefore allow States, where they felt it appropriate to encourage HMOs to participate in their medicaid programs, to guarantee the HMOs payment for each medicaid enrollee for a minimum period of up to 6 months after initial enrollment, and to receive the appropriate Federal matching payments. This guarantee of a six-month enrollment would apply only to individuals who involuntarily lost eligibility; medicaid beneficiaries who voluntarily disenrolled due to dissatisfaction or for other reasons could not be covered under such an arrangement.

The Committee bill does not address this issue of payment methodology. Under current medicaid regulation, prepaid capitation or other risk based payment arrangements are subject to an upper ceiling that is the lesser of (1) the cost of providing those services on a fee-for-service basis, or (2) comparable payments by other third-party payors. The Committee intends that these ceilings remain in place, so that a State could not pay more to an HMO under medicaid than the Federal Government paid to the HMO under medicare for comparable services and populations. Within this ceiling, the Committee expects that States will negotiate prudent, actuarially sound, and cost-effective payment arrangements with HMOs that will stimulate wider HMO participation in the medicaid program.

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V. Program Oversight

The Committee's principal oversight activities with respect to this program have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of the legislative authorities for this program. Legislative hearings were held on March 18, 1981. The findings of the committee's oversight activities are discussed in this report under "committee proposal," as the proposed legislation is designed to respond to the Subcommittee findings.

The Committee has not received reports from either its own Subcommittee on Oversight and Investigations or the Committee on Government Operations.

VI. Inflation Impact Statement

The Committee anticipates that the enactment of H.R. 3399 will have a beneficial impact on inflation by reducing the rate of increase in medical care costs. Recent studies indicate that HMOs are generating substantial savings to their members. Because HMOs have a financial incentive to keep their members well, and because HMOs have been successful in reducing the rate of hospitalization for their members, HMOs have generated cost savings of 10 percent to 40 percent.

The Committee also expects that HMOs will compete with the fee for service system and with other forms of health insurance on the basis of price. Such competition will play an important role in restraining the rate of increase in the costs of all health providers and in the premiums charged by other forms of health insurance. By fostering this competition this legislation will have a beneficial impact on the rate of inflation in medical care costs.

VII. Congressional Budget Office Cost Estimate

A cost estimate was requested on H.R. 3399 when it was ordered reported from the Committee on Energy and Commerce, and the Congressional Budget Office has provided the following information:

U.S. Congress,
Congressional Budget Office,
Washington, D.C., May 20, 1981.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 3399, a bill to amend titles XVIII and XIX of the Social Security Act with respect to payments to health maintenance organizations.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

James Blum
(For Alice M. Rivlin, Director).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 3399.

2. Bill title: A bill to amend titles XVIII and XIX of the Social Security Act with respect to payments to health maintenance organizations.

3. Bill status: As ordered reported by the House Committee on Energy and Commerce on May 12, 1981.

4. Bill purpose: The bill would encourage the enrollment of Medicare and Medicaid beneficiaries in health maintenance organizations (HMOs). Under Medicare, the bill would provide for reimbursement of an HMO on the basis of a prospectively determined amount per capita equal to 95 percent of the cost of obtaining the same care outside the HMO. Any reimbursement in excess of an HMO's adjusted community rate would be returned to its Medicare beneficiaries in the form of additional benefits or reduced charges and premiums. Under Medicaid, the bill would ease some of the requirements for participation of HMOs and would allow states to guarantee the Medicaid eligibility of an HMO enrollee for a maximum of six months.

5. Cost estimate:

Medicare

	Millions
Estimated budget authority:	
Fiscal year:	
1982	-----
1983	$1
1984	4
1985	9
1986	10
Estimated outlays:	
Fiscal year:	
1982	-----
1983	2
1984	10
1985	20
1986	20

The costs of this bill fall within function 550.

6. Basis of estimate: Generally, the Medicare provisions of the bill would become effective 13 months after enactment and the Medicaid provisions 5 quarters after enactment. Assuming enactment in September 1981, then, all provisions would take effect October 1, 1982 and the bill would have no costs in fiscal year 1982. The estimates of costs in future years are described below.

Medicare

H.R. 3399 would provide incentives to increase enrollment of Medicare beneficiaries in HMOs. Under current law, HMOs can choose either cost reimbursement or a risk contract for Medicare beneficiaries. Only one HMO, Group Health of Puget Sound, has elected the risk contract. Benefits and cost-sharing arrangements provided by HMOs under these reimbursement methods do not provide incentives for Medicare beneficiaries to leave the fee-for-service sector. The new risk contract would provide for capitation payments that would allow efficient HMOs to offer Medicare beneficiaries increased benefits and reduced out-of-pocket expenditures.

The bill would raise costs in the short run. Higher payments for current enrollees who would convert to the new contract would

initially outweigh savings from new enrollees. These conversions, however, would be limited by the bill: one current enrollee would be allowed to convert for each two new enrollees.

Conversions would increase Medicare outlays in the following way. On average, efficient HMOs treat Medicare beneficiaries at approximately 80 percent of adjusted average per capita cost (AAPCC), which is the cost of treatment in the fee-for-service sector. The bill would reimburse HMOs at 95 percent of this rate, or 15 percentage points over the costs of an efficient HMO. Consequently, assuming that efficient HMOs would be most likely to offer the new risk agreement, Medicare would pay more under the bill for current HMO enrollees who adopt the new risk contract. This would also be true for current HMO enrollees not yet eligible for Medicare who will become eligible in the future.

New enrollments of Medicare beneficiaries in HMO's would reduce outlays, because the proposed reimbursement rate of HMO's is 5 percent lower than Medicare payments for the same services outside HMO's. Medicare enrollment in HMO's is assumed to triple by 1987 if the bill is enacted. It is assumed that HMO's with 220,000 Medicare enrollees would adopt the new risk agreement in 1983. On the basis of the results of a recent demonstration project, it is also assumed that new enrollment of Medicare beneficiaries would be 60 percent of projected Medicare enrollment in that year.

Not all current enrollees would choose to convert to the new risk arrangement. It is assumed that one-third of current enrollees would convert in the first year, another 10 percent in the second year, and an ultimate conversion of 50 percent would be realized by the end of the third year.

Given these assumptions, the calculation of costs is straightforward. The number of enrollees under current law (projected using a 10 percent annual growth rate) is multiplied by 15 percent of AAPCC.[1] The total is then adjusted for the effects of the one existing risk contract. The estimated number of new enrollees is multiplied by 5 percent of AAPCC. The bill's cost is the difference between the first total and the second. As noted above, H.R. 3399 would have no cost in fiscal year 1982.

In the long run, Medicare outlays might be reduced by the bill. HMO's should be able to provide a more attractive benefit package to Medicare beneficiaries and, thus, increase their Medicare enrollments. Eventually, savings from this new enrollment would outweigh the costs of converting present enrollees. At the assumed growth rates of Medicare enrollment in HMO's, H.R. 3399 would begin producing Medicare savings by the beginning of the next decade.

Medicaid

By encouraging the participation of HMO's in Medicaid, the Medicaid provisions of H.R. 3399 could eventually yield small savings. Those provisions would ease some of the requirements for participation of HMO's and would allow states to guarantee the Medicaid eligibility of an HMO enrollee for up to six months. The latter change

[1] AAPCC is estimated to be $1,940 in 1983, $2,190 in 1984, $2,450 in 1985, and $2,740 in 1986.

could potentially assure some stability to an HMO's Medicaid enrollment, thereby diminishing the HMO's administrative and marketing costs and reducing retroactive denials of reimbursements on grounds of ineligibility.

It is difficult to estimate the effect of these changes on Medicaid spending. In deciding whether to guarantee eligibility, States would have to balance potential costs in the short run (before Medicaid enrollment in HMOs begin to grow) against potential savings in the long run. It seems unlikely, given their currently tight budgets, that States would take action that would raise spending today, even with the prospect of future savings. Further, it is unclear how HMOs would respond to the bill's changes. Guaranteed enrollment for 6 months may not sufficiently alleviate the disenrollment problem, and other obstacles to HMO participation in Medicaid remain. Given these uncertainties, it is assumed that the bill would have no significant impact on Medicaid spending before 1987.

7. Estimate comparison: Although the Administration has estimated the costs of this bill, the information needed to explain differences in the estimates is not available at this time.

8. Previous CBO estimate: At the request of staff of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, CBO prepared an informal estimate of the costs of a similar bill on May 5, 1981. That estimate does not differ significantly from the estimate above.

9. Estimate prepared by: Steven Sheingold (225–9785) and Malcolm Curtis.

10. Estimate approved by:

James L. Blum,
Assistant Director for Budget Analysis.

VIII. Agency Reports

Agency reports were requested on H.R. 2508, a similar predecessor to H.R. 3399, on March 15, 1981 from the Office of Management and Budget and the Department of Health and Human Services.

No reports had been received when this report was filed.

IX. Section-by-Section Analysis

The purpose of this bill is to amend the Social Security Act to revise the manner in which health maintenance organizations are reimbursed by Medicare and Medicaid. An additional amendment is made to section 1122 regarding review of capital expenditures.

AMENDMENTS TO TITLE 18 AND SECTION 1122 OF THE SOCIAL SECURITY ACT

Section 1(a):

Section 1876(a)(1): Every year the Secretary would determine a per capita rate of payment for each class of individuals who are enrolled with a HMO (as defined in subsection (b)(1)) and who are covered by either parts A and B or part B only of Medicare. The rate would be equal to 95 percent of the "adjusted average per capita cost" for each class.

Section 1876(a)(2): The "adjusted average per capita cost" is the per capita amount the Secretary estimates would be paid for services provided to Medicare beneficiaries by other providers (physicians, hospitals, etc.) in the geographic area of the HMO.

Section 1876(a)(3): In establishing the classes of individuals for purposes of subsection (a)(1), the Secretary would take into consideration such factors as age, sex, institutional and disability status, and place of residence.

Section 1876(a)(4): The Secretary would make monthly payments to the HMO for each enrolled Medicare beneficiary.

Section 1876(a)(5): The payment to an HMO for Medicare beneficiaries would be made from the Federal Hospitalization Insurance Trust Fund (part A) and the Federal Supplementary Medical Insurance Trust Fund (part B).

Section 1876(b)(1): The definition of "health maintenance organization" is either a qualified health maintenance organization (under Title 13) or a public or private organization, organized under State law, which provides certain inpatient and outpatient services and out-of-area coverage; is compensated on prepaid basis; provides physicians services through employees, partners, or under contract; assumes full financial risk on a prospective basis for all covered health care services (four exceptions are permitted—see pages 5 and 6 of bill); and makes adequate provision against the risk of insolvency.

Section 1876(b)(2): In addition to meeting the definition of (b)(1), the health maintenance organization must also comply with several conditions of participation:

(1) The HMO would have to provide to Medicare beneficiaries those services included in parts A and B and could provide any additional health care services approved by the Secretary or elected by the beneficiary.

(2) Copayments for the provision of part A and B services to Medicare beneficiaries could not exceed the limits described in subsection (g).

(3) The HMO must provide all part A and B services to Medicare beneficiaries through institutions, entities and persons which meet the requirements of section 1861 of the Social Security Act.

(4) The HMO would have to have an annual open enrollment period for Medicare beneficiaries which is of reasonable duration and during which it accepts beneficiaries up to the limits of its capacity and without restricting (except per regulations) and in the order in which they apply. The enrollment period would be closed for the year if its continuation would result in more Medicare beneficiaries than are permitted by subsection (h) (that is, greater than 50 percent or more Medicare beneficiaries than their proportion in the population in the geographic area of the HMO.

(5) The HMO could not expel or refuse to reenroll any Medicare beneficiary because of health status and must notify each beneficiary of such fact.

(6) Required services must be available and accessible to Medicare beneficiaries and, when medically necessary, on a 24 hour a day, seven day a week basis; and reimbursement must be provided for medically necessary services received from a provider other than the organization.

(7) The HMO must provide a meaningful grievance procedure for Medicare beneficiaries.

(8) The HMO must have an ongoing quality assurance program for health services provided to Medicare beneficiaries.

Section 1876(c): The HMO would be paid directly. The Medicare beneficiary would receive no payments.

Section 1876(d): Every Medicare beneficiary covered by parts A and B or part B only (except those individuals with end-stage renal disease) could enroll with any participating HMO in their area.

Section 1876(e): The Secretary of HHS may promulgate regulations regarding enrollment practices. Medicare beneficiaries enrolled at risk with the HMO may terminate their enrollment at the beginning of the first calendar month following a full calendar month after the termination is requested.

Section 1876(f): An enrolled Medicare beneficiary with a controversy regarding services or charges of $100 or more may have a hearing before the Secretary of HHS, and if the amount in $1,000 or more, have judicial review of the Secretary's decision.

Section 1876(g)(1): An HMO's premium rate, deductibles, coinsurance or copayments charged to enrolled Medicare beneficiaries may not exceed the actuarial value of the coinsurance and deductibles applicable on the average to the HMO's enrolled Medicare beneficiaries if they were not enrolled.

Section 1876(g)(2): The HMO may provide services in addition to those covered by parts A and B at the Secretary's approval or at the option of the enrolled Medicare beneficiary and then only after advising the enrolled beneficiary of the additional premium or charge for those additional services. The premium or the actuarial value of the deductible, coinsurance and copayment charged for the additional services may not exceed the "adjusted community rate" for those services.

Section 1876(g)(3): The "adjusted community rate" for a service is either the rate of payment annually estimated by the Secretary of HHS that would apply in a HMO which uses the "community rating system" required by section 1302(8) of the Public Health Service Act or the portion of the weighted aggregate premium attributable to that service in a HMO which does not use the "community rating system" of section 1302(8), if the community rate or weighted aggregate premium for non-Medicare individuals in that HMO were adjusted to reflect differences in utilization between them and Medicare beneficiaries.

Section 1876(g)(4): If an enrolled Medicare beneficiary were also entitled to benefits under a worker's compensation law or an insurance policy, the HMO could charge under those other policies for services rendered.

Section 1876(h): A participating HMO may have no more than 75 percent of its total enrollment with Medicare beneficiaries and Medicaid recipients. However, the Secretary of HHS can modify or waive this requirement as long as Medicare beneficiaries constitute no more than 50 percent of total enrollment.

Section 1876(i)(1–2): The Secretary of HHS would enter into risk contracts with HMOs which choose to participate. The contract

would provide that if the adjusted community rate of enrolled Medicare beneficiaries (reduced for the actuarial value of the coinsurance and deductible is less than the average of the per capita payments made to the HMO, the HMO would provide additional benefits to those beneficiaries which are, as determined by the Secretary of HHS, at least equal in value to the difference between the adjusted community rate and the average per capita payment.

Section 1876(i)(3): The additional benefits would be (a) the reduction of the premium rate or other charges or (b) provision of additional health benefits, or both.

Section 1876(i)(4): The effective date of the contract shall be specified in the contract.

Section 1876(i)(5): Under the contract the Secretary or her designee could inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed and could audit or inspect any books and records of the HMO pertaining to the capacity of the organization to bear the risk of potential financial losses and pertaining to services performed or the determinations of amounts payable under the contract. The HMO would have to provide written notice to its enrolled Medicare beneficiaries in advance of termination of the contract and devise them of alternatives for obtaining their Medicare benefits. The contract would contain other conditions determined by the Secretary to be necessary.

Section 1876(i)(7): If an HMO terminated a contract, the Secretary could not agree to another contract for five years except in special circumstances as determined by the Secretary.

Section 1876(i)(8): The Secretary of HHS may carry out this section without regard to other provisions of law regarding contacts which are inconsistent with this title.

Section 1876(j): If the Secretary determined that an HMO could not bear the risk of providing services or if an HMO elected, the Secretary could enter into a contract with the HMO to reimburse the HMO on a reasonable cost basis. (This is the same option as in current law.)

Section 1(b) and (c)

Amend section 1861(s)(2) and section 1861(aa) to clarify that "Medical and other health services" which a HMO must provide to an enrolled Medicare beneficiary may include the services of physician assistants and nurse practitioners.

Section (d)

Coverage of capital expenditures under section 1122 of the Social Security Act would be the same as such coverage under section 1527 of the Public Health Service Act (the Health Planning Act). (Section 1(d)(2) of the bill is a conforming amendment.)

Section 1(e)

The effective date of this new section would be the first day of the thirteenth month after enactment or earlier for any HMO which requests such effectiveness and for which the Secretary of HHS agrees. This new section would not apply (1) to any Medicare bene-

ficiary enrolled on the date a contract is agreed to unless the beneficiary requests such application and the Secretary determines that administrative costs or burdens warrant such application and so informs each affect members; or (2) for five years after enactment to an HMO which has a risk-based contract under current section 1976(i)(2)(A) unless the HMO requests earlier application.

Section 1(f)

The Secretary would conduct a study of the additional benefits selected by HMOs pursuant to new section 1876(i)(2) and report to the Congress within 24 months.

AMENDMENTS TO TITLE 19 OF THE SOCIAL SECURITY ACT

Section 2(a)

Section 1903(m)(1)(A): A health maintenance organization is defined as a public or private entity that meets either (a) the requirements for federal qualification under Title XIII of the Public Health Service Act or (b) the requirements of section 1876(b)(1) relating to benefits, prepayment, organization of physicians' services, risk, and involvency.

In addition to meeting one of these sets of requirements, the entity must:

(1) provide most of the mandatory Medicaid benefits;

(2) provide assurances that it will not expel or refuse to re-enroll any Medicaid enrollee due to health status;

(3) make its services available and accessible to Medicaid enrollees and provide for out-of-area emergency coverage;

(4) establish grievance procedures for Medicaid enrollees;

(5) establish an ongoing quality assurance program for Medicaid enrollees.

Section 1903(m)(B): The Office of the Assistant Secretary for Health is responsible for making the determination as to whether an entity qualifies as an HMO. (This provision is unchanged from current law).

Section 1903(m)(2)(A): The Federal Government will not make any matching payments to a State for Medicaid expenditures to a provider on a risk basis unless:

(1) the entity is an HMO as defined in section 1903(m)(1)(A);

(2) no more than 75 percent of the enrollees are Medicare or Medicaid-eligibles;

(3) the State Medicaid Agency has entered into a contract with the HMO;

(4) the contract provides that the Secretary of the State agency has the right to audit and inspect all relevant books and records;

(5) the contract prohibits discrimination in enrollment on the basis of health status; and

(6) the contract provides for notification of each Medicaid eligible of that person's right to voluntarily disenroll without cause upon one month's notice.

Section 1903(m)(2)(B): Certain organizations that were functioning as HMOs before June 30, 1976, are exempt from the new HMO qualification requirements. (This provision is unchanged from current law).

Section 1903(m)(2)(C): Gives HMOs three years from the date of entering into a contract with the State to meet the requirement than not more than 75 percent of their membership may be Medicaid or Medicare beneficiaries. (The only change in this provision from current law is the increase in the enrollment ceiling from 50 percent to 75 percent).

Section 1903(m)(2)(D): Authorizes the Secretary to waive the 75-percent Medicare-Medicaid enrollment limitation for public entities, but only if the Secretary determines that the waiver is warranted by special circumstances and that the entity is making reasonable efforts to enroll private patients.

Section 1903(m)(3): If the Secretary does not act on an application for HMO status within 90 days, a State may make a provisional determination until the Secretary acts. (This provision is unchanged from current law).

Section 2(b)

Section 1902(e)(2)(A): The Federal Government will make matching payments to States at their option for expenditures to HMOs on behalf of enrollees for an enrollment period of 6 months, even if the enrollee has involuntarily lost his or her Medicaid eligibility (e.g., due to excess income) before the expiration of the 6 month period.

Section 2(c)

The effective date of these Medicaid amendments is the first day of the first calendar quarter beginning more than one year after enactment, or earlier with respect to an HMO if the HMO so requests and the Secretary and State agree. The amendments would not affect contracts entered into by a State and an HMO before the effective date.

Section 3

The Secretary is required to study and report to Congress on the extent of, and reasons for, disenrollment by Medicare and Medicaid beneficiaries from HMOs.

Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

* * * * * * *

Part A—General Provisions

* * * * * * *

Limitation on Federal Participation for Capital Expenditures

SEC. 1122. (a) * * *

* * * * * * *

(j) A capital expenditure made by or on behalf of a health care facility shall not be subject to review pursuant to this section if the obligation of the capital expenditure by the facility would not be required to be reviewed under section 1527 of the Public Health Service Act.

* * * * * * *

Disclosure of Ownership and Related Information

SEC. 1124. (a)(1) * * *

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization [(as defined in section 1301(a) of the Public Health Service Act)];

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

Part C—Miscellaneous Provisions

Definition of Services, Institutions, etc.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies; [and]

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens

so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician, *and*

(H) services furnished pursuant to a contract under section 1876 to a member of a health maintenance organization by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

* * * * * * *

Rural Health Clinic Services

(aa)(1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10).

(B) such services furnished by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of

its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services on such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has appropriate procedures for review of ultilization of clinic services to the extent that the Secretary determines to be necessary and feasible; and

(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a health manpower shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of class (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

Alcohol Detoxification Facility Services

(bb) (1) The term "alcohol detoxification facility services" means services provided by a detoxification facility in order to reduce or eliminate the amount of alcohol in the body, but only to the extent that such services would be covered under subsection (b) if furnished as inpatient services by a hospital, or are physicians' services covered under subsection (s).

(2) The term "detoxification facility" means a public or voluntary community-based nonprofit facility, other than a hospital, which—

(A) is engaged in furnishing to inpatients the services described in paragraph (1);

(B) is accredited by the Joint Commission on the Accreditation of Hospitals as meeting the Accreditation Program for Psychratic Facilities standards (1979 edition), or is found by the Secretary to meet such standards;

(C) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and

(D) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.

Comprehensive Outpatient Rehabilitation Facility Services

(cc) (1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self administered;

(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

(2) The term "comprehensive outpatient rehabilitation facility" means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative

services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

Physician Assistant and Nurse Practitioner

[(3)] (*dd*) The term "physician assistant" and the term "nurse practitioner" mean[, for the purposes of paragraphs (1) and (2),] a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

* * * * * * *

[Payments to Health Maintenance Organizations

[Sec. 1876. (a)(1) In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, but only with respect to a health maintenance organization with which he has entered into a contract under subsection (i), a per capita rate of payment—

[(A) for services provided under parts A and B for individuals enrolled with such organization pursuant to subsection (e) who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B, and

[(B) for services provided under part B for individuals enrolled with such organization pursuant to subsection (e) who are not entitled to benefits under part A but who are enrolled for benefits under Part B.

[(2) An interim per capita rate of payment for each health maintenance organization shall be determined annually by the Secretary on the basis of each organization's annual operating budget and enrollment forecast which shall be submitted (in such form and in such detail as the Secretary may prescribe) at least 90 days before the beginning of each contract year. Each interim rate shall be equal to the estimated per capita cost (based upon types and components of expenses otherwise reimbursable under this title) of providing services defined in paragraph (3)(A)(iii). In the event that the data requested to be furnished by a health maintenance organization are not furnished timely, such reduction in interim payments may be made by the Secretary as is appropriate, until such time as a reasonable estimate of per capita costs can be made. Each month, the Secretary shall pay each such organization its interim per capita rate, in advance, for each individual enrolled with it pursuant to subsection (e). Each such organization shall submit interim estimated cost reports and enrollment data on a quarterly basis in such form and manner satisfactory to the Secretary, and the Secretary shall adjust each interim per capita rate to the extent necessary to maintain interim payments at the level of current costs. Interim payments made under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

[(3)(A) With respect to any health maintenance organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i)(2)(A), payments made to such organization shall be subject to the following adjustments at the end of each contract year:

[(i) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is less than the adjusted average per capita incurred cost (as defined herein) of providing such services, the resulting difference (hereinafter referred to as "savings") shall be apportioned following the close of a contract year for such year between such organization and the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (hereinafter collectively referred to as the "Medicare Trust Funds") as follows:

[(I) savings up to 20 percent of the adjusted average per capita cost shall be apportioned equally between such organization and the Medicare Trust Funds;

[(II) savings in excess of 20 percent of the adjusted average per capita cost shall be apportioned entirely to such Trust Funds;

[(ii) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is greater than the adjusted average per capita incurred cost of providing such services, the resulting difference (hereinafter referred to as "losses"), shall be absorbed by such organization, and shall be carried forward and offset from savings realized in later years;

[(iii) determination of any amounts payable at the close of the contract year to such organization or to the Trust Funds shall be made as follows:

[(I) within in 90 days after close of a contract year, interim determination of the amount of estimated savings and apportionment thereof shall be made, actuarially, on the basis of interim reports of costs incurred by an organization, and adjusted average per capita costs incurred (as defined herein), and other evidence acceptable to the Secretary and one-half of any amounts deemed payable to such organization or the Trust Funds shall be paid by such organization or the Secretary as appropriate;

[(II) final settlement and payment by the Secretary or organization, as appropriate, of any additional amounts due on basis of such final settlement will be made where adequate data for actuarial computation are available, in timely fashion following submission by such organization of reports specified in subparagraph (C) of this paragraph; and

[(III) where such final settlement is reached more than 90 days following submission of reports specified in subparagraph (C) of this paragraph, any amount payable by the Secretary or organization shall be increased by an interest amount, accruing from the 91st day following submission of such report, equal to the average rate of interest payable on Federal obligations if issued on such 91st day for purchase by the Trust Funds.

[(iv) The term "adjusted average per capita cost" means the average per capita amount that the Secretary determines (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and date, in the geographic area served by a health maintenance organization or in a similar area, with appropriate adjustment to assure actuarial equivalence, including adjustments relating to age distribution, sex, race, institutional status, disability status, and any other relevant factors) would be payable in any contract year for services covered under this title and types of expenses otherwise reimbursable under this title (including administrative costs incurred by organizations described in sections 1816 and 1842) if such services were to be furnished by other than such health maintenance organization.

[(B) With respect to any health maintenance organization which has entered into a reasonable cost reimbursement contract with the Secretary pursuant to subsection (i)(2)(B), payments made to such organization shall be subject to suitable retroactive corrective adjust-

ments at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of health services) for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in paragraph (1).

[(C) Any contract with a health maintenance organization under this title shall provide that the Secretary shall require, at such time following the expiration of each accounting period of a health maintenance organization (and in such form and in such detail) as he may prescribe:

[(i) that such health maintenance organization report to him in an independently certified financial statement its per capita incurred cost based on the types and components of expenses otherwise reimbursable under this title for providing services described in paragraph (1), including therein, in accordancee with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

[(ii) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

[(iii) that in any case in which a health maintenance organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the health maintenance organization by related organizations and owners) issued by the Secretary in accordance with section 1861(v) of the Social Security Act; and

[(iv) that in any case in which compensation is paid by a health maintenance organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

[(4) The payments to health maintenance organizations under this subparagraph with respect to individuals described in subsection (a)(1)(A) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of such payment to such an organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

[(A) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(1), and

[(B) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1))

who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(4).

[The remainder of such payment shall be paid by the former trust fund. For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

[(b)(1) The term "health maintenance organization" means a legal entity which provides health services on a prepayment basis to individuals enrolled with such organizations and which—

[(A) provides to its enrollees who are insured for benefits under parts A and B of this title or for benefits under part B alone, through institutions, entities, and persons meeting the applicable requirements of section 1861, all of the services and benefits covered under such parts (to the extent applicable under subparagraph (A) or (B) of subsection (a)(1)) which are available to individuals residing in the geographic area served by the organization;

[(B) provides such services in the manner prescribed by section 1301(b) of the Public Health Service Act, except that solely for the purposes of this section—

[(i) the term "basic health services" and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

[(ii) the organization shall not be required to fixe the basic health services payment under a community rating system;

[(iii) the additional nominal payments authorized by section 1301(b)(1)(D) of such Act shall not exceed the limits applicable under subsection (g) of this section; and

[(iv) payment for basic health services provided by the organization to its enrollees under this section or for services such enrollees receive other than through the organization shall be made as provided for by this title;

[(C) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act, except that solely for the purposes of this section—

[(i) the term "basic health services" and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

[(ii) the organization shall not be reimbursed for the cost of reinsurance except as permitted by subsection (i) of this section; and

[(iii) the organization shall have an open enrollment period as provided for in subsection (k) of this section.

[(2)(A) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a "health maintenance organization" within the meaning of paragraph (1), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

[(B) Except as provided in subparagraph (A), the Secretary shall administer the provisions of this section through the Administrator of the Health Care Financing Administration.

[(c) The benefits provided under this section to enrollees of an organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i)(2)(A) shall consist of—

[(1) in the case of an individual who is entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B—

[(A) entitlement to have payment made on his behalf for all services described in section 1812 and section 1832 which are furnished to him by the health maintenance organization with which he is enrolled pursuant to subsection (e) of this section; and

[(B) entitlement to have payment made by such health maintenance organization to him or on his behalf for (i) such emergency services (as defined in regulations), (ii) such urgently needed services (as defined in regulations) furnished to him during a period of temporary absence (as defined in regulations) from the geographic area served by the health maintenance organization with which he is enrolled, and (iii) such other services as may be determined, in accordance with subsection (f), to be services which the individual was entitled to have furnished by the health maintenance organization, as may be furnished to him by a physician, supplier, or provider of services, other than the health maintenance organization with which he is enrolled; and

[(2) in the case of an individual who is not entitled to hospital insurance benefits under part A but who is enrolled for medical insurance benefits under part B, entitlement to have payment made for services described in paragraph (1), but only to the extent that such services are also described in section 1832.

[(d) Subject to the provisions of subsection (e), every individual described in subsection (c) shall be eligible to enroll with any health maintenance organization (as defined in subsection (b)) which serves teh geographic area in which such individual resides.

[(e) An individual may enroll with a health maintenance organization under this section, and may terminate such enrollment, as may be prescribed by regulations.

[(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive without additional cost to him any health service to which he believes he is entitled shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b) and in any such hearing the Secretary shall make such health maintenance organization a party thereto. If the amount in controversy is $1,000 or more, such individual or health maintenance organization shall be entitled to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(g)(1) If the health maintenance organization provides its enrollees under this section only the services described in subsection (c),

its premium rate or other charges for such enrollees shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B, if they were not enrolled under this section.

[(2) If the health maintenance organization provides its enrollees under this section services in addition to those described in subsection (c), election of coverage for such additional services shall be optional for such enrollees and such organization shall furnish such enrollees with information on the portion of its premium rate or other charges applicable to such additional services. The portion of its premium rate or other charges applicable to the services described in subsection (c) shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B if they were not enrolled under this section.

[(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have an enrolled membership at least half of which consists of individuals who have not attained age 65.

[(2) The Secretary may waive the requirement imposed in paragraph (1) for a period of not more than three years from the date a health maintenance organization first enters into an agreement with the Secretary pursuant to subsection (i), but only for so long as such organization demonstrates to the satisfaction of the Secretary by the submission of its plan for each year that it is making continuous efforts and progress toward compliance with the provisions of paragraph (1) within such three-year period.

[(i)(1) Subject to the limitations contained in subparagraphs (A) and (B) of paragraph (2), the Secretary is authorized to enter into a contract with any health maintenance organization which undertakes to provide, on an interim per capita prepayment basis, the services described in section 1832 (and section 1812, in the case of individuals who are entitled to hospital insurance benefits under part A) to individuals enrolled with such organization pursuant to subsection (e).

[(2)(A) If the health maintenance organization (i) has a current enrollment of not less than 25,000 members on a prepaid capitation basis and has been the primary source of health care of at least 8,000 sons in each of the three years immediately preceding the contract year, or (ii) serves a nonurban geographic area, has a current enrollment of not less than 5,000 members on a prepaid capitation basis and has been the primary source of health care for at least 1,500 persons in each of the three years immeditaely preceding the contract year, the Secretary may enter into a risk sharing contract with such organization pursuant to which any savings, as determined pursuant to subsection (a)(3)(A), are shared between such organization and the Medicare Trust Funds in the manner prescribed in such subsection. For purposes of this subparagraph, a health maintenance organization shall be considered to serve a nonurban geographic area if it is located in a nonmetropolitan county (that is, a county with fewer than 50,000 inhabitants), or if it has at least one such county in its normal service area, or if it is located outside of a metropolitan area and its facilities are within reasonable travel distance (as defined by the Secretary) of fewer than 50,000 individuals. No health main-

tenance organization which has entered into a risk-sharing contract with the Secretary under this subparagraph and has voluntarily terminated such contract may again enter into such a contract.

[(B) If the health maintenance organization does not meet the requirements of subparagraph (A), or if the Secretary is not satisfied that the health maintenance organization has the capacity to bear the risk of potential losses as determined under clause (ii) of subsection (a)(3)(A), or if the health maintenance organization meeting the requirements of subparagraph (A) so elects, or if an organization does not fully meet the requirements of section 1876(b) but has demonstrated to the satisfaction of the Secretary that it is making reasonable efforts to meet, and is developing the capability to fully meet, such requirements, and that it fully meets such basic requirements as the Secretary shall prescribe in regulations, the Secretary may, if he is otherwise satisfied that the health maintenance organization or other organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in subsection (a)(3)(B).

[(3) Such contract may, at the option of such organization, provide that the Secretary (A) will reimburse hospitals and skilled nursing facilities for the reasonable cost (as determined under section 1861(v) of services furnished to individuals enrolled with such organization pursuant to subsection (e), and (B) will deduct the amount of such reimbursement from payments which would otherwise be made to such organization. If a health maintenance organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

[(4) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds that the organization (A) has failed substantially to carry out the contract, (B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (C) no longer substantially meets the applicable conditions of subsection (b).

[(5) The effective date of any contract executed pursuant to this subsection shall be specified in such contract pursuant to the regulations.

[(6) Each contract under this section—

[(A) shall provide that the Secretary, or any person or organization designated by him—

[(i) shall have the right to inspect or otherwise evaluate the quality, appropriatness, and timeliness of services performed under such contract; and

[(ii) shall have the right to audit and inspect any books and records of such health maintenance organization which pertain to services performed and determinations of amounts payable under such contract;

[(B) shall provide that no reinsurance costs (other than costs with respect to out-of-area services and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year), including any underwriting of risk relating to costs in excess of adjusted average per capita cost, as defined in clause (iii) of subsection (a)(3)(A), shall be allowed for purposes of determining payments authorized under this section; and

[(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

[(j) The function vested in the Secretary by subsection (i) may be performed without regard to such provisions of law or of other regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

[(k) Each health maintenance organization with which the Secretary enters into a contract under this section shall have an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of subsection (h)) or would result in enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such health maintenance organization.]

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1876. (a)(1) The Secretary shall annually determine a per capita rate of payment—

(A) for each class of individuals who are enrolled (in accordance with this section) with a health maintenance organization which has entered into a contract under this section (other than under subsection (j)) and who are entitled to benefits under part A and enrolled under part B; and

(B) for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

Such rate for each class shall be equal to 95 percent of the adjusted average per capita cost for that class.

(2) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by a health maintenance organization or in a similar area, with appropriate adjust-

ments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than a health maintenance organization or, in the case of services covered only under section 1861(s)(H), if the services were to be furnished by a physician or as an incident to a physician's service.

(3) In establishing classes of individuals for purposes of this subsection, the Secretary shall take into consideration such factors as age, institutional status, disability status, and place of residence and such other factors as the Secretary determines to be appropriate.

(4) After determining under paragraph (1) the rate of payment to be utilized with respect to a health maintenance organization, the Secretary shall make monthly payments, in advance and in accordance with such rate, except as provided in subsections (i)(2) and (j), to such organization for each individual enrolled in accordance with this section with the organization. Such payments (and payments made under subsection (j)) shall be in lieu of payments which (in the absence of the contract entered into under this section) would be payable otherwise pursuant to section 1814(b) or 1833(a) for services furnished by or through the organization to individuals enrolled with the organization and entitled to benefits under part A and enrolled under part B or enrolled under part B only.

(5) The payment to a health maintenance organization under this section for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(1); and

(B) the product of (i) the number of such individuals for the month who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(4).

The remainder of that payment shall be paid by the former trust fund.

(b)(1) For purposes of this section, the term "health maintenance organization' means a public or private organization, organized under the laws of any State, which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) or which—

(A) provides to enrolled members at least the following health care services: physicians' services performed by physicians (as defined in section 1861(r)(1)), inpatient hospital services, laboratory, X-ray, emergency, and preventive health services, and out-of-area coverage;

(B) is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided;

(C) provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis);

(D) assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that a health maintenance organization may—

(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

(ii) obtain insurance or make other arrangements for the cost of health care service listed in subparagraph (A) provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions; and

(E) has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

(2) The Secretary may not enter into a contract with a health maintenance organization under this section, unless, with respect to individuals enrolled with the organization under this section, the following requirements are met:

(A) BENEFIT PACKAGE.—The organiaztion must provide to such individuals who are—

(i) entitled to benefits under part A and enrolled under part B, only those services covered under parts A and B of this title, or

(ii) only enrolled under part B, only those services covered under such part,

except that, in addition, the organization (other than an organization with a contract under subsection (j)) may provide such individuals with such additional health care services either as the Secretary may approve or as such individuals may elect, at their option, to have covered. The Secretary shall approve any such additional health care services which the organization proposes

to offer to such individuals, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(B) LIMITS ON DEDUCTIBLES, COINSURANCE, AND COPAYMENTS.—The amount of any deductibles, coinsurance, and copayments required of such individuals will not exceed the limits applicable under subsection (g) of this section.

(C) PROVIDERS.—The organiaztion must provide the services described in subparagraph (A) to such individuals through institutions, entities, and persons meeting the applicable requirements of this title and of part A of title XI.

(D) OPEN ENROLLMENT.—The organization must have an open enrollment period, for the enrollment of individuals under this section, of reasonable duration at least every year during which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet requirements of subsection (h) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(E) EXPULSION OF MEMBERS.—The organization must (i) provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and (ii) notify each such individual of such fact at the time of the individual's enrollment.

(F) AVAILABILITY OF SERVICES.—The organization must—

(i) make the services described in subparagraph (A) (and such other health care services as such individuals have contracted for) (I) available and accessible to each such individual, within the area served by the organization, promptly as appropriate and in a manner which assures continuity, and (II) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(ii) provide for reimbursement with respect to services which are described in clause (i) and which are provided to such an individual other than through the organization, if the services were medically necessary and immediately required because of an unforseen illness, injury, or condition.

(G) GRIEVANCE PROCEDURES.—The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and such individuals.

(H) QUALITY ASSURANCE.—The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (i) stresses health outcomes and (ii) provides review by physicians and other health care professionals of the process followed in the provisions of such health care services.

(c) If an individual is enrolled in accordance with this section with a health maintenance organization (other than an organization with a contract under subsection (j)), only the health maintenance organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

(d) Subject to the provisions of subsection (e), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any health maintenance organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e) (1) An individual may enroll under this section with a health maintenance organization as may be prescribed in regulations and may terminate his enrollment with the health maintenance organization as of the beginning of the first calendar month following a full calendar month after the request is made for such termination or, in the case of such an organization with a contract under subsection (j), as may be prescribed by regulations.

(2) The Secretary may prescribe the procedures and conditions under which a health maintenance organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization.

(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the health maintenance organization a party. If the amount in controversy is $1,000 or more, the individual or health maintenance organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the health maintenance organization shall be entitled to be parties to that judicial review.

(g) (1) In no case may—

(A) the portion of a health maintenance organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled in accordance with this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B) to individuals who are enrolled in accordance with this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled in accordance with this section with the organization (or, if the Secretary finds

that adequate data are not available to determine that actuarial value, other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of a health maintenance organization.

(2) If the health maintenance organization provides to its enrollees under this section services in addition to services covered under parts A and B of this title, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (b)(2)(A)) shall be optional for such enrollees and such organization shall furnish such enrollees with information on the portion of its premium rate or other charges applicable to such additional services. Except for an organization with a contract under subsection (j), in no case may the sum of—

(A) the portion of such organization's premium rate charged, with respect to such additional services, to individuals enrolled in accordance with this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services, to such individuals

exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service means, at the election of a health maintenance organization, either—

(A) the rate of payment for that service which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with a health maintenance organization if the rate of payment were determined under "a community rating system" (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with the health maintenance organization, as the Secretary annually estimates is attributable to that service,

but adjusted for differences between the utilization characteristics of the individuals enrolled with the health maintenance organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals in other health maintenance organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with a health maintenance organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the health maintenance organization may (in the case of the provision of services to an individual enrolled in accordance with this section for an illness or injury for which the member is entitled to benefits under a workman's compensation law or under an insurance policy) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

(A) the insurance carrier, employer, or other entity which under such law or policy is to pay for the provision of such services, or

(B) such member to the extent that such member has been paid under such law or policy for such services.

(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-quarter of which consists of individuals who are not entitled to benefits under part A or enrolled under part B or entitled to benefits under a State plan approved under title XIX.

(2) The Secretary may modify or waive the requirement described in paragraph (1) only (A) if the Secretary determines that (i) special circumstances warrant such modification or waiver, and (ii) the health maintenance organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX, and (B) on the condition that the organization will not have, for the duration of such contract, an enrolled membership of which one-half or more are individuals entitled to benefits under part A or enrolled under part B.

(i)(1) The Secretary may enter into a contract with any health maintenance organization, as defined in subsection (b)(1), for the purpose of carrying out this section.

(2) Each contract (other than a contract described in subsection (j)) shall provide that—

(A) if the adjusted community rate, as defined in subsection (g)(3), for services covered under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if such adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for individuals enrolled in accordance with this section with the organization and enrolled under part B only

is less than the average of the per capita rates of payment to be made under subsetcion (a)(1) at the beginning of an annual contract period for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the health maintenance organization shall provide to individuals enrolled in accordance with this section (other than under a contract under subsection (j)) with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B, respectively, additional benefits which are selected by the health maintenance organization and which the Secretary finds are at least equal in value to the difference between the average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average

per capita payment and adjusted community rate (as so reduced). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

(3) Such additional benefits shall be (A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to individuals enrolled under this section, or (B) the provision of additional health benefits, or both.

(4)(A) Each contract under this section shall be for a term of at least one year, as determined by the Secretary and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds the organization (i) has failed substantially to carry out the contract, (ii) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (iii) no longer substantially meets the applicable conditions of subsection (b).

(B) The effective date of any contract executed pursuant to this section shall be specified in the contract.

(5) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and

(ii) shall have right to audit and inspect any books and records of the health maintenance organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, and (II) to services performed or determinations of amounts payable under the contract,

(B) shall require the organization (other than an organization with a contract under subsection (j)) to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization, and

(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

(7) The Secretary may not enter into contract with a health maintenance organization under this section (other than under subsection (j)) if a former contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(8) The authority vested in the Secretary by this subsection may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of

contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(j)(1) If—

(A) the Secretary is not satisfied that a health maintenance organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this section, or

(B) the health maintenance organization so elects,

the Secretary may, if he is otherwise satisfied that the health maintenance organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in paragraph (3), rather than on the basis described in subsection (a)(4).

(2) Such contract under this subsection may, at the option of such organization, provide that the Secretary (A) will reimburse hospitals and skilled nursing facilities for the reasonable cost (as determined under section 1861(v)) of services furnished to individuals enrolled with such organization pursuant to subsection (e), and (B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization. If such a health maintenance organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(b)) unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(3) Payments made to an organization with a contract under this subsection shall be subject to suitable retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) for the types of expenses otherwise reimburable under this title for providing services covered under this title to individuals described in subsection (a)(1).

(4) Any contract with a health maintenance organization under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the health maintenance organization (and in such form and in such detail) as he may prescribe—

(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this title for providing services described in subsection (a)(1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

(C) that in any case in which a health maintenance organization is related to another organization by common ownership or

control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the health maintenance organization by related organizations and owners) issued by the Secretary in accordance with section 1861(v); and

(D) that in any case in which compensation is paid by a health maintenance organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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State Plans for Medical Assistance

SEC. 1902. (a) * * *

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(e)(*1*) Notwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.

(2)(A) In the case of an individual who is enrolled with a health maintenance organization (under a contract described in section 1903(m)(2)(A)) and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such organization.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with a health maintenance organization under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization becomes effective.

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Payment to States

SEC. 1903. (a) * * *

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(m)(1)(A) The term "health maintenance organization" [means a legal entity which provides health services to individuals enrolled in such organization and which—

[(i) provides to its enrollees who are eligible for benefits under this title the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905, and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a);

[(ii) provide such services and benefits in the manner prescribed in section 1301(b) of the Public Health Service Act (except that, solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section, shall be deemed to refer to the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a), and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph 7 of section 1905(a)); and

[(iii) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act (except that solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1905(a)(1), (2), (3), (4)(C), and (5), and to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)).] *means a public or private organization, under the laws of any State, which is a qualified health maintenance organization (as defined in section 1301(d) of the Public Health Service Act) or meets the requirements of subparagraphs (A) through (E) of section 1876 (b)(1), and which meets the following requirements with respect to individuals enrolled with the organization and eligible for benefits under this title:*

(i) BENEFIT PACKAGE.—The organization must provide to such individuals the services and benefits described in paragraphs (1), (2)(A), (3), (4)(B), (4)(C), and (5) of section 1905(a), and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under the State plan, the services and benefits described in section 1905(a)(7).

(ii) EXPULSION OF MEMBERS.—The organization must (I) provide assurances to the State that it will not expel or refuse to reenroll any such individual because of the individual's health status or requirements for health care services, and (II) notify each such individual of such fact at the time of the individual's enrollment.

(iii) AVAILABILITY OF SERVICES.—The organization must—

(I) make the services described in clause (i) available and accessible to each such individual, within the area served by

the organization, promptly as appropriate and in a manner which assures continuity, and when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(II) provide for reimbursement with respect to services which are described in subclause (I) and which are provided to such an individual other than through the organization, if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(iv) GRIEVANCE PROCEDURES.—The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and such individuals.

(v) QUALITY ASSURANCE.—The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (I) stresses health outcomes and (II) provides review by physicians and other health care professionals of the process followed in the provisions of such health care services.

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A) shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

(2)(A) Except as provided in subparagraphs (B) and (C), on payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary (or the State as authorized by paragraph (3)) has determined that the entity is a health maintenance organization as defined in paragraph (1); [and]

(ii) less than [one-half] *three-quarters* of the membership of the entity consists of individuals who (I) are insured for benefits under part B of title XVIII or for benefits under both parts A and B of such title, or (II) are eligible to receive benefits under this title[.];

(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, and (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment of individuals who are eligible for benefits under this title and eligible to enroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services; and

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) provides for notification of each such individual, at the time of individual's enrollment, of such right to terminate such enrollment.

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(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that (i) special circumstances warrant such modification or waiver, and (ii) the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the state plan approved under this title or under title XVIII.

Section 3 of Public Law 95–210

AN ACT To amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes

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DEMONSTRATION PROJECTS FOR PHYSICIAN-DIRECTED CLINICS IN URBAN MEDICALLY UNDERSERVED AREAS

SEC. 3. (a)

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(e) As used in this section, the terms "physician assistant" and "nurse practitioner" have the meanings given such terms in section 1861[(aa)(3)] *(dd)* of the Social Security Act.

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